



DIVISION OF DEVELOPMENTAL DISABILITIES  
Olympia, Washington

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TITLE: USE OF PSYCHOACTIVE MEDICATIONS POLICY 5.16

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Authority: Chapter 71A RCW Developmental Disabilities  
Chapter 388-101 WAC Certified Community Residential Services and  
Supports

### **BACKGROUND**

Psychoactive medications have proven to be a very effective treatment for many forms of mental illness. As with other prescription medications, psychoactive medications have the potential for unwanted side effects. Regular monitoring for side effects and evaluation of medication effectiveness is especially important for individuals who have a reduced capacity to communicate symptoms of potential side effects.

Psychoactive medications are not necessarily the first or only treatment of choice, particularly for challenging behaviors. Positive behavior support approaches may be equally or more effective and treatment decisions should always be made on an individual basis. Refer to Division of Developmental Disabilities (DDD) Policies 5.14, *Positive Behavior Support*, and 5.15, *Use of Restrictive Procedures* for additional information and requirements.

### **PURPOSE**

This policy establishes guidelines for assisting a client with mental health issues or persistent challenging behavior to access accurate information about psychoactive medications and treatment, and to make fully informed choices.

### **SCOPE**

This policy applies to the use of psychoactive medications by clients who receive medication services through:

1. DDD contracted residential programs serving people in their own homes, including the State Operated Living Alternatives (SOLA);

2. Companion Homes; and
3. Licensed Staffed Residential Homes and Group Care Facilities (for children/youth).

### **DEFINITIONS**

**Medication administration** is the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the body of the client by an individual legally authorized to do so.

**Medication assistance** is assistance with self-administration of medication rendered by a nonpractitioner to a client receiving certified community residential services and supports in accordance with RCW 69.41 and chapter 246-888 WAC.

**Medication service** is any service provided by a certified community residential services and support provider related to medication administration or medication assistance provided through nurse delegation and medication assistance.

**Psychoactive** means possessing the ability to alter mood, anxiety level, behavior, cognitive processes, or mental tension, usually applied to pharmacological agents.

**Psychoactive medications** means medications prescribed to treat a mental illness, improve functioning, or reduce challenging behaviors. Psychoactive medications include antipsychotics/neuroleptics, atypical antipsychotics, antidepressants, anticonvulsants, stimulants, sedatives/hypnotics, and anti-mania and anti-anxiety drugs. Anticonvulsants and other classes of drugs are included in this category when they are prescribed for behavioral purposes.

### **POLICY**

Psychoactive medications are prescribed to enable a person to function better, reduce challenging behavior, or treat a mental illness. Persons with developmental disabilities and mental illness, and/or persistent challenging behavior shall have appropriate access to information and treatment with psychoactive medications, and reasonable protection from serious side effects or the inappropriate use of these medications.

If a psychoactive medication is used to treat a physical condition (e.g., sleep or seizure disorder) and is not also used for behavioral purposes, the requirements of this policy do not apply. Positive behavior support strategies, if warranted, should be integrated in the person's overall support plan.

**PROCEDURES**A. Assessment

1. If the client appears to be displaying symptoms of mental illness and/or persistent challenging behavior, refer the person for a professional assessment. It is important to rule out any physical or medical conditions that may be causing or contributing to the behavior. It is recommended that a psychiatrist, physician's assistant, general practitioner, or nurse practitioner (ARNP) with experience in treating people with developmental disabilities conduct this assessment.
2. Prior to the assessment, staff will prepare a psychiatric referral summary and send or take this to the treatment professional conducting the assessment. The summary should briefly describe the frequency and severity of the client's symptoms or behaviors and what has been tried previously. See Attachment A for sample form, *Psychiatric Referral Summary*.

Note: Some clients may prefer to visit their treatment professional independently and without the assistance of residential agency staff. In such cases, respect the person's choice and document this in the client record and Plan of Care (POC). Also document in the service plan/POC whether the person is assessed as capable of self-monitoring his/her medications or requires assistance.

B. Treatment Plan

1. After the assessment, if the treatment professional recommends psychoactive medication for ongoing or PRN use, the prescribing professional or agency staff will document this in a Psychoactive Medication Treatment Plan. See Attachment B for sample form, *Psychoactive Medication Treatment Plan*. The plan must include the following:
  - a. A description of the behaviors, symptoms or conditions for which the medication is prescribed and a mental health diagnosis, if available;
  - b. The name, dosage, and frequency of the medication (subsequent changes in dosage may be documented in the person's medical record);
  - c. The length of time considered sufficient to determine if the medication is effective (i.e., treatment trial);
  - d. The behavioral criteria to determine whether the medication is effective (i.e., what changes in behavior, mood, thought, or functioning are considered evidence that the medication is effective); and

- e. The anticipated schedule of visits with the prescribing professional.
2. The PMTP must be updated whenever there is a change in medication.
3. The prescribing professional is responsible for obtaining informed consent when necessary from the client or, if applicable, his/her legal representative. Agencies must retain a copy of the signed consent form, if available, in the person's record. If the person's legal representative refuses to give consent, the agency should encourage the legal representative to meet with the treatment professional to discuss the medication issue.
4. Agency staff will review with the client and his/her legal representative the name, purpose, potential side effects and any known potential drug interactions of the medication. Agency staff should base such discussion on the written information supplied by the dispensing pharmacy whenever possible. See Attachment C for sample form, *Information Regarding Psychoactive Medication*.
5. Agencies must have available to staff and clients an information sheet for each psychoactive medication that is being used by persons served by the agency. This information sheet should describe potential side effects and potential adverse drug interactions that may occur from use of the medication. This information sheet should be one provided by the dispensing pharmacy or based on information provided by the dispensing pharmacy whenever possible.
6. There may be situations in which a client's legal representative is unavailable or unwilling to provide consent. Where, in the physician's opinion, no significant risks are associated with the medication, the agency should act in the client's best interest and assist him/her in obtaining and taking the medication.
7. If positive supports have been identified that will assist in the treatment, reduction, or elimination of the client's symptoms or behaviors, document these in a written plan.

C. Monitoring Psychoactive Medications

1. The agency must monitor the client to help determine if the medication is being effective based on criteria identified in the PMTP. If the medication does not appear to have the desired effects, the agency must communicate this to the prescribing professional.
2. The agency must observe the client for any changes in behavior or health that might be side effects of the medication and inform the prescribing professional of any concerns.

3. The agency should request that the prescribing professional see the client at least every three (3) months unless the prescribing professional recommends a different schedule. Document the visitation schedule in the client's treatment plan.
4. Continued need for the medication and possible reduction should be assessed at least annually by the prescribing professional. See Attachment D for sample form, *Psychoactive Medication Treatment Plan: Annual Continuation of Medication*.

**EXCEPTIONS**

Any exceptions to this policy must have the prior written approval of the division director.

**SUPERSESSSION**

DDD Policy 5.16  
Issued September 1, 2005

DDD Policy 5.16  
Issued November 1, 2003

DDD Policy 5.16  
Issued July 1, 2001

DDD Policy 5.16  
Issued May 26, 1999

DDD Policy 5.16  
Issued January 30, 1996

Approved: /s/ Donald L. Clintsman for Linda Rolfe  
Director, Division of Developmental Disabilities

Date: July 1, 2006

**ATTACHMENT A**

**PSYCHIATRIC REFERRAL SUMMARY**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_

Supporting Agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Legal Representative: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

DDD Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Briefly describe why this person is being referred for a psychiatric evaluation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Symptom(s) or behavior(s) of concern (define and state frequency and severity of each symptom or behavior):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous mental health involvement (list past counseling, behavioral interventions, diagnoses, medications, psychiatric hospitalizations, crisis team contact, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENT A**

**PSYCHIATRIC REFERRAL SUMMARY (continued)**

List other agency contacts and phone numbers (employment, vocational, mental health, other therapists, etc.):

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What has been tried previously (list intervention and results, if known):

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List diagnoses/medical concerns:

Current medications and daily dose:

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List any known unusual or adverse reactions to medications:

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Describe the following characteristics of the person (if not already listed):

Sleep pattern \_\_\_\_\_

Mood/affect \_\_\_\_\_

Eating/appetite \_\_\_\_\_

Thinking/cognition \_\_\_\_\_

Memory \_\_\_\_\_

Anxiety level \_\_\_\_\_

Hyperactivity \_\_\_\_\_

Sensory impairments \_\_\_\_\_

**ATTACHMENT A**

**PSYCHIATRIC REFERRAL SUMMARY (continued)**

Allergies \_\_\_\_\_

Gynecological problems \_\_\_\_\_

Urinary problems \_\_\_\_\_

Communication impairment \_\_\_\_\_

Other Information that may be pertinent:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ATTACHMENT B**

**PSYCHOACTIVE MEDICATION TREATMENT PLAN**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Supporting Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Description of behavior(s) for which medication is prescribed and a mental health diagnosis, if available:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication(s):

Dosage and Frequency:

_____	_____
_____	_____
_____	_____

Trial period (how long before an effect should be noticed):

\_\_\_\_\_

Behavioral criteria to evaluate effectiveness of medication (what changes in behavior, mood, thought or functioning should be expected):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Potential interactions with other drugs/food:

\_\_\_\_\_  
\_\_\_\_\_

Prescribing Professional: \_\_\_\_\_ Phone: \_\_\_\_\_

Return for medication monitoring:  1 month  3 months  6 months  Other: \_\_\_\_\_

\_\_\_\_\_  
Name of Person Completing Form

**ATTACHMENT C**

**INFORMATION REGARDING PSYCHOACTIVE MEDICATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Description of behavior for which medication is prescribed and mental health diagnosis, if available:

\_\_\_\_\_  
\_\_\_\_\_

Medication(s):

Dosage and Frequency:

_____	_____
_____	_____
_____	_____
_____	_____

Information on medication: attach information sheet(s) that describe the medication, dosage ranges, possible side effects and potential adverse drug interactions.

Questions regarding the use of this medication should be addressed to the prescribing professional listed below.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Information reviewed with the client/legal representative on: \_\_\_\_\_.

\_\_\_\_\_  
Name of Person Completing Form

**To be completed by client/legal representative:**

I have received information on this medication, the reasons for its use, and I have had the opportunity to get my questions about it answered.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client's Legal Representative

\_\_\_\_\_  
Date

**ATTACHMENT D**

**PSYCHOACTIVE MEDICATION TREATMENT PLAN  
ANNUAL CONTINUATION OF MEDICATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Supporting Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Description of behavior for which medication is prescribed and mental health diagnosis, if available:

\_\_\_\_\_  
\_\_\_\_\_

Medication(s):

Dosage and Frequency:

_____	_____
_____	_____
_____	_____
_____	_____

Positive results of this medication and justification for continuation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan to continue use of this medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Schedule return visit in:

\_\_\_\_\_

\_\_\_\_\_  
Name of Person Completing Form